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RELATIONSHIPS, AUTONOMY AND LEGAL CAPACITY: MENTAL CAPACITY AND SUPPORT PARADIGMS

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ABSTRACT

Within law and legal scholarship there are different models of legal personality and legal capacity. The most well known of these emphasises individual rationality, and is distilled into the medico-legal concept of 'mental capacity'. In connection with the UN Convention on the Rights of Persons with Disabilities (CRPD) a new approach to legal personality is being developed, emphasizing relationships of support and recognition of universal legal capacity. Recent scholarship on both 'mental capacity' and CRPD approaches to legal capacity have drawn from feminist writings on relational autonomy. In this paper, I use this scholarship on relational autonomy to explore the differences between these approaches to legal capacity. I argue that the approach connected with the CRPD offers a refreshing take on the importance of relationships of support in exercising legal capacity. However, despite their pronounced differences, especially in relation to the legitimacy of coercion, there are remarkable similarities in the underlying challenges for each approach: the extent to which others can 'know' our authentic and autonomous selves, and the inextricable relationships of power that all forms of legal capacity are embedded within.

INTRODUCTION

Law and legal scholarship recognizes a diverse family of legal practices concerned with the concepts of 'legal personality' and 'legal capacity', which govern whether and how different entities may enjoy legal rights and duties (Tur, 1987). Naffine (2003) describes how different models of legal personality and legal capacity hinge on different metaphysical prerequisites, and have different normative implications for the kinds of rights and duties different legal entities may enjoy and how they may exercise them. In its barest sense, legal personality is simply a functional placeholder that could be

occupied by *any* entity that bears some kind of right or duty. Human rights approaches connect legal personality to any *human*, regardless of their individual capacities. The most prized form of legal personality is termed the 'responsible subject' by Naffine (p. 362-364)—the "classic contractor" who is "rational and therefore responsible", can sue and be sued, can be held liable for his actions, and is considered autonomous.

This 'responsible subject' is distilled into the medico-legal concept of 'mental capacity', which refers to the ability to make a particular decision; and in those areas where a person is found to lack 'mental capacity' third parties may make decisions on their behalf in their best interests. The Mental Capacity Act 2005 (MCA) of England and Wales is a well-known example of a mental capacity law.¹ While this approach was itself considered visionary only a decade or so ago, it is now being challenged by an emerging new model of legal personality and legal capacity, connected with Article 12 of the United Nations (2006) Convention on the Rights of Persons with Disabilities (CRPD). In its more radical form, this model entirely divorces legal capacity from 'mental capacity' approaches. It is grounded in the social model of disability, which views disability as resulting from the interaction between a person's individual make-up (including any 'impairment' they may have) with their social environment. The social model emphasises addressing barriers and environmental adaptations, rather than 'fixing' or 'curing' individuals (Oliver, 1990; Shakespeare, 2013).

This new approach treats a person's agency as shaped or even constituted by their environment and relationships with others. Instead of casting 'mental incapacity' as an individual deficit, resulting in a loss of legal capacity, it calls for the provision of whatever support is necessary to ensure that disabled people are able to exercise full legal capacity on an equal basis with others, and addressing discriminatory attitudes and barriers that might limit the recognition and exercise of legal capacity by disabled persons. This approach to legal personality is sometimes known as the 'support paradigm', or a paradigm of '*universal* legal capacity'. The United Nations Committee on the Rights of Persons with Disabilities (2014) endorsed this approach in its General Comment on Article 12 CRPD. The General Comment maintains that Article 12 prohibits the imposition of 'substitute decisions' on people with disabilities, requiring instead that they are given access to the support they need to exercise their legal capacity in accordance with their will and preferences. There is growing concern that the MCA contravenes Article 12 CRPD (Bartlett, 2012a; Martin, 2014; Richardson, 2013).

¹ This approach can also be found in several human rights instruments from the 1990s (e.g. Council of Europe 1999; United Nations, 1991), and in many other national laws.

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In order to unpack the emergence of this new paradigm of legal personality and legal capacity, this paper contrasts the metaphysical foundations and normative implications of 'mental capacity' and 'support paradigm' approaches, using case studies to illustrate their differences. It draws from relational theories of autonomy, which are increasingly invoked within the developing literature on each approach. By examining each approach through the lens of relational autonomy (RA), it becomes apparent that they have importantly different metaphysical underpinnings, which have implications for how they translate into legal frameworks and everyday life. Laws like the MCA are primarily based on the idea that mental capacity is the property of an individual, and this approach struggles to produce clear and consistent principles for accommodating the influences of others – both positive and negative – on decision making. Mental capacity approaches emphasise the importance of interventions that can enhance individual decision making, but these interventions, which ostensibly aim to promote autonomy, can be remarkably coercive. This is an important difference from 'support paradigm' approaches.

The support paradigm literature offers a new take on the importance of autonomy over and within relationships; a perspective that is often neglected in the literature on the MCA. However, its emphasis on *consensual* support raises difficult questions about how this approach can manage situations of risk where a person rejects support, or situations of exploitation, abuse and undue influence by supporters. Responses in the literature to these 'hard cases' are discussed.

Both approaches are concerned with the boundaries of personhood, and responsibility for, and ownership of, decisions. Despite their pronounced differences, especially in relation to the legitimacy of coercion, there are remarkable similarities in the underlying challenges for each approach: the extent to which others can 'know' our authentic and autonomous selves, and the inextricable relationships of power that all forms of legal capacity are embedded within. This paper does not aim to resolve all the complex questions raised by these approaches to legal capacity; rather it hopes to promote further reflection on their metaphysical foundations and normative implications.

THEORIES OF RELATIONAL AUTONOMY

According to contemporary feminist thought, for better or worse, our acts and decisions, values and beliefs, our very identities, are profoundly influenced by our relationships with others. This idea sits in tension with liberal philosophies that idealise moral and political subjects as self-sufficient and independent of others' influence; subjects who are considered 'autonomous'. This feminist intuition has inspired a diverse family of critiques that argue that autonomy itself has social and relational

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dimensions. These theories of autonomy have had a profound impact on the new approaches to legal personality and legal capacity that provide the focus for this paper.

Beyond agreement that autonomy is valuable, but cannot be divorced from relational and social conditions, RA approaches are very diverse (Mackenzie & Stoljar, 2000; Stoljar, 2013). Causal accounts emphasise the importance of external causal conditions, such as relationships with parents, teachers and friends, that provide the necessary 'support and guidance' for the development of autonomy (Nedelsky, 1989, p. 12). Others, like Oshana (2006), go further, and argue that social and relational conditions are *constitutive* of autonomy; regardless of a person's individual make-up, they are not autonomous unless certain social and relational conditions are satisfied. Oshana's constitutive account is more tolerant of non-consensual interventions to 'rescue' individuals from oppressive social circumstances, even if they themselves have chosen to live in such circumstances. For this reason it has attracted criticism by scholars who prefer models of autonomy that place a greater emphasis on *individual* capacities for reasoning and reflection (Christman, 2004; Holroyd, 2009;).

RA approaches can also encompass symbolic critiques of Western culture's idealisation of a 'masculine' ideal of autonomy - atomistic, self-sufficient, rational and unemotional (Brown, 2002; Code, 1991; Mackenzie & Stoljar, 2000; Scott, 1996). Much of the 'support paradigm' scholarship could be viewed as engaging in a similar symbolic critique (e.g. Quinn & Arstein-Kerslake 2012). 'Ethic of care' approaches, that emphasise the value of relationships of care and interdependency, are also sometimes connected with RA (Mackenzie & Stoljar, 2000: 8–10; Herring, 2013a: 72). However, some disability scholars have criticized the "ethic of care" as being insufficiently attentive to rights and power relations within relationships of care (Herring, 2013; Shakespeare, 2013). Tensions between 'ethic of care' and 'rights based' approaches to support can be discerned in the mental capacity and support paradigm literature.

Theories of autonomy have an important influence on models of legal personality. Individual liberal models are most obviously associated with Naffine's 'responsible subject', but RA approaches are increasingly invoked in connection with both 'mental capacity' and 'support paradigm' approaches to legal capacity. Because of their diverse metaphysical, ethical and political underpinnings, RA approaches can be used to advocate for very different positions. This is reflected in the very different ways they are used in the literature on legal personality and capacity: on the one hand, RA approaches are being used to rehabilitate mental capacity models, and on the other they are being used to reject them altogether. Legal scholars should exercise caution when praying in aid 'relational' approaches; because of their diversity it is far from self-evident how these should translate into legal frameworks or everyday life.

MENTAL CAPACITY AND RELATIONAL AUTONOMY

Although 'mental capacity' is not synonymous with moral and political philosophies of autonomy (Owen et al, 2009), in many respects its legal functions are closely analogous. Christman and Anderson (2005, p.3) describe liberal understandings of autonomy as meaning that freedom and responsibility flow from a person satisfying competence and authenticity requirements. Mental capacity law is structured similarly: a person is accorded legal rights and responsibilities only insofar as they are found to be competent and their decisions are authentically theirs. However, an examination of the MCA's case law reveals that the courts struggle to reconcile the influence of relationships to competence and authenticity requirements connected with mental capacity, resulting in complex and sometimes contradictory rulings.

Value neutral or substantive autonomy?

Under the MCA, a person is considered unable to make a decision if they are unable to understand, retain, or use or weigh the relevant information – including about the reasonably foreseeable consequences – or to communicate their decision.² This 'functional' approach was preferred to tests based on the outcome of a decision³ (Law Commission, 1991), and the MCA cautions that a person is not to be regarded as 'incapable' merely because they make an unwise decision.⁴ This resembles a procedural 'value neutral' approach to autonomy, rather than substantive approaches that require people to hold certain values or decide in a particular way in order to be regarded as autonomous (Christman & Anderson, 2005; Mackenzie & Stoljar, 2000, p.13; Stoljar, 2013). However several commentators argue that mental capacity does, inevitably, contain substantive commitments (Banner, 2012; Charland, 2001; Craigie, 2013; Freyenhagen & O'Shea, 2013; Holroyd, 2012). Empirical research suggests that assessors find it very difficult to distinguish between 'incapacitous' and 'unwise' decisions (Emmett et al., 2012; Williams et al., 2012). Some argue that the value judgments underlying mental capacity assessments should be made more transparent (Freyenhagen & O'Shea, 2013; Kong, 2014).

Acknowledging that mental capacity assessment is not 'value neutral' raises the question of *whose* values should inform the assessment – the person's own, the assessors, or wider societal values?

² s3(1) MCA. Please note, that a person who is 'unable to make a decision' is only regarded as lacking mental capacity if certain causal conditions contained within s2(1) MCA are also satisfied; this is discussed below.

³ Outcome tests might, for example, consider the 'reasonableness' of a decision.

⁴ s1(4) MCA

Several RA approaches to mental capacity argue that it should be assessed by reference to the person's own values; the implications of this are discussed below.

Internalism or externalism?

O'Shea (2011) and Ashley (2013) characterize accounts of autonomy as either *internalist* – requiring only 'internal' decision making capacities, authenticity conditions and attitudes to self to be satisfied – or *externalist*, requiring certain external 'enabling conditions' to be satisfied such as freedom from duress, manipulation, coercion and domination. Externalist accounts – like Oshana's (2006) – mean that a person who satisfies *internal* criteria for autonomy could still be regarded as non-autonomous because of their oppressive relationships or social circumstances. As noted above, such accounts can be controversial if they endorse non-consensual interventions in situations where a person is considered 'oppressed' but still satisfies 'internal' criteria for autonomy (Christman, 2004; Holroyd, 2009). Questions of internalism and externalism also arise for mental capacity, and can inspire similar controversies about the appropriateness of interventions where people may be 'incompetent' or 'competent' but for their relationships with particular individuals.

In some senses, the MCA resembles 'internalist' approaches to autonomy, as it includes an additional causation requirement whereby people are only treated as lacking mental capacity if they are unable to make a decision "*because of* an impairment of, or a disturbance in the functioning of, the mind or brain"⁵. This causation requirement encodes a 'medical' or 'individual' model of incapacity, contrasting with the *social* models of disability that underpin the support paradigm. This causation requirement takes the courts into tricky metaphysical territory: how should they distinguish between the entangled effects of impairment, social surroundings and biography?⁶ Some disabled people have successfully argued that they *had* mental capacity, by attributing decision making difficulties to other causes than an impairment – for example a relationship with a predatory sex offender⁷, religious beliefs⁸ or a 'challenging personality'.⁹ Paradoxically, given these uses, this may also constitute a form of disability discrimination (Carson, 1993; Martin, 2014).

⁵ s2(1) MCA

⁶ For an example of the difficulties, see: *Re PB* [2014] EWCOP 14

⁷ *PC & Anor v City of York Council* [2013] EWCA Civ 478

⁸ *Re P (capacity to tithe inheritance)* [2014] EWHC B14 (COP)

⁹ *Wandsworth Clinical Commissioning Group v IA* [2014] EWHC 990 (COP)

Tensions between internalist and externalist accounts of mental capacity can also be observed in a series of cases concerning consent to sex. Public authorities have repeatedly argued that a person's mental capacity to consent to sex is affected by relationships with sexual partners, but the courts have resisted this interpretation out of concern that it could result in paternalistic and intrusive "vetting" of potential sexual partners (Series, 2015).¹⁰ These rulings have been criticised by feminist theorists for not attending to the relational dimensions of decision making (Clough, 2014; Herring & Wall, 2014). Yet if mental capacity assessments did take into account the deleterious effects of particular relationships this could permit *more* paternalistic interventions, evoking similar controversies to externalist constitutive approaches to autonomy like Oshana's, which permit coercive interventions on the basis of the properties of oppressive relationships.

Relationships as threats to autonomy

It would not be correct, however, to say that the MCA is *never* attentive to relational aspects of decision making. On a number of occasions, the courts have authorized interventions to restrict contact with third parties who are said to exercise such a negative influence over a person's decision making that they lack mental capacity. In some cases, the 'rescued' individuals adamantly opposed such interventions¹¹, in others the person's 'true' views were disputed. For example, in *LBX v K*, L was said to be "poorly equipped to resist" the overbearing influence of his father, and he voiced conflicting preferences to different people.¹² Once removed from the care of his father, he expressed a preference not to see him.

In *London Borough of Redbridge v G*,¹³ a local authority received numerous safeguarding referrals about a 94 year old woman called G, concerning two individuals who had moved into her home. Witnesses described seeing C and F shouting and screaming at G¹⁴, isolating her from family and friends and felt that she was scared of them. C and F had told G that if she asked them to leave she would be placed in a care home, and the local authority was unable to convince her of their plans to

¹⁰ *IM v LM* [2014] EWCA Civ 37. A very different approach is taken in the criminal sphere; see *R v Cooper* [2009] UKHL 42.

¹¹ *A Primary Care Trust v P* [2009] EW Misc 10 (EWCOP); *A Local Authority v WMA & Ors* [2013] EWHC 2580 (COP)

¹² *LBX v K, L, M* [2013] EWHC 3230 (Fam), §15

¹³ [2014] EWHC 17 (COP)

¹⁴ One alleged they had witnessed her being physically shaken, but the court made no finding of fact regarding this allegation.

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

support her to remain at home. At various points G had asked "for some government authority to intervene on her behalf"¹⁵, and had told a doctor and independent social worker that she was like "the fly in the spider's web"¹⁶. Yet in the presence of C and F, including in the courtroom and before journalists, G insisted that she wanted them to remain. The court concluded that G lacked the mental capacity to decide (*inter alia*) whether the individuals should continue to live with her. It held that she was "paralysed with fear by the threats regarding her removal to a care-home".¹⁷ The court held that her *true* wishes and feelings were hard to discern; notwithstanding G's objections in court, it authorised the removal of the individuals from her home, and a care plan to support her to remain there and be re-integrated into her church and social world.

These rulings suggest that – outside the sphere of consent to sex at least – the courts treat mental capacity as being partially constituted by freedom from oppressive relationships with others.

Relationships as enabling autonomy

The RA literature also emphasises that relationships can *foster* autonomy, through providing appropriate support (Nedelsky, 1989). Analogously, the MCA requires that "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success".¹⁸ This is sometimes known as the 'support principle', but it differs in important ways to the support paradigm connected with the CRPD, discussed below. The MCA Code of Practice suggests selecting an appropriate time and place to conduct the assessment, presenting information in different ways, and involving others who may be able to help them make a decision (Lord Chancellor's Office, 2007, Chapter 3).¹⁹ Courts have required measures such as providing sex education²⁰ or setting out all the options for a person rather than starting with a 'blank canvas'²¹ to help a person attain mental capacity.

¹⁵ *London Borough of Redbridge v G & Ors* [2014] EWHC 485 (COP) §17

¹⁶ *London Borough of Redbridge v G & Ors* [2014] EWHC 17 (COP), §10

¹⁷ n13, §79

¹⁸ s1(3) MCA. See also s3(2) which requires that information is presented in a way that is appropriate to a person's circumstances.

¹⁹ Section 4 of the Mental Capacity Bill (Northern Ireland) 2014 explicitly codifies these provisions.

²⁰ *D Borough Council v AB* [2011] EWHC 101 (COP)

²¹ *CC v KK and STCC* [2012] EWHC 2136 (COP)

The MCA's support principle is framed in the passive voice: it is not immediately obvious *who* must provide this support, and what that support should look like. The duty will fall upon whoever relies upon an assertion that a person lacks mental capacity. In some cases this might be people nominated under Lasting Powers of Attorney (LPA)²² or court appointed deputies²³, but the vast majority of health and welfare decisions will be made under the MCA's 'general defence'.²⁴ This codified the common law position²⁵ that a person who performs an act of care or treatment in the best interests of a person who lacks mental capacity will have the same protection from liability that they would have had if the person had consented to it. Thus support under the MCA is not structured holistically – it is atomised across different decisions and dispersed over a large number of disparate actors who might rely upon the general defence.

Perhaps because the MCA couples 'support' duties to whoever asserts mental incapacity, the RA literature on the MCA focuses almost exclusively on support in the context of mental capacity assessment. Mackenzie and Rogers (2013) describe mental capacity as inherently "dialogical", as dialogue is required for assessors to distinguish between 'unwise' and 'incapacitous' decisions. They argue that this dialogue can itself foster authentic and autonomous decision making. They argue²⁶ that the MCA endorses a diachronic conception of authentic agency, requiring capacity assessors to consider whether a person's decision is consistent with their long-standing values, beliefs and commitments. They suggest that mental capacity assessors can provide the necessary 'social scaffolding' to promote diachronically coherent decisions. 'Hermeneutic' approaches also emphasise the role of dialogue in mental capacity assessment in promoting authentic decisions, through searching for a person's 'true' meaning in verbal and non-verbal communication, and affording the person 'the possibility of developing a personal narrative' (Benaroyo & Widdershoven, 2004, p. 305; cited by Donnelly, 2010). Similarly, Banner and Szmukler (2013) take inspiration from Davidson (1973)

²² s9-14 MCA

²³ s16 MCA

²⁴ s5-6 MCA

²⁵ *Re F. (Mental Patient: Sterilisation)* [1990] 2 A.C. 1; [1991] UKHL 1

²⁶ Citing Westlund (2009) and Taylor (1989).

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to argue that assessors should explore a person's values and beliefs to identify 'incapacity' within the person's own moral frame of reference.²⁷

There is much wisdom in exhortations to try to understand other people's values and frames of meaning, and that dialogue can promote authentic and diachronically coherent decision making. However, there is little acknowledgement in these RA accounts that mental capacity assessment is "embedded in unequal power relations between professionals and individuals" (Beaupert & Steele, 2014). This is no ordinary dialogue: assessors must – on these accounts – at some point come to a view as to a person's 'true' or authentic values and beliefs, and assess their decisions against these. Dialogical approaches thus implicitly confer upon mental capacity assessors 'epistemic privilege' to know a person's 'true' values and beliefs and how these have influenced their reasoning. Yet as Skowron (2014, citing Kittay, 2009) comments, there are reasons for requiring "epistemic modesty" here, being clear about the limits of assessors' knowledge.

Stefan (1992-1993) describes capacity as "a value judgment arising from an individual's conversation or communication with individuals in positions of power", and failures of communication are attributed only to the less powerful side of the dialogue. The point was eloquently made by LT, who exclaimed to her capacity assessor, with palpable frustration, "I want to go home – why don't you understand that?"²⁸ Whose is the failing of understanding here? Problems may arise where a person's frame of meaning is difficult to communicate and hard to understand (Carel & Kidd, 2014), especially if they live in radically different bodies and social circumstances to assessors.

These approaches necessarily require the assessed person to engage in dialogue with assessors about their values, beliefs and reasoning; little attention has been paid to how this might be experienced. Although, as Smzukler (2009. p. 649) suggests, some people may experience this conversation as "therapeutic", it is far from clear that all will. Assessments could easily be experienced as intrusive, or as a taxing demand to 'construct a convincing case' (Morgan & Veitch, 2004) in order to retain control over matters of great personal significance. Case law offers several examples of people who were found to lack mental capacity by assessors whom they did not like or trust – and thus refused to co-operate with – only to be found to have mental capacity by other assessors whom they felt less

²⁷ A similar relational and hermeneutic approach to mental capacity assessment is being developed by Camillia Kong as part of a British Academy Postdoctoral Fellowship at the University of Oxford (personal communication, 2014). A book on this subject is anticipated.

²⁸ *RT v LT & Anor* [2010] EWHC 1910 (Fam) §32

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antipathy towards.²⁹ A relationship of trust cannot always be presumed, and the identity of the assessor matters a great deal.

The RA literature on the MCA typically assumes that clinicians – or sometimes social welfare professionals - will play the role of supporting and assessing mental capacity (e.g. Banner & Szmukler, 2013; Benaroyo & Widdershoven, 2004; Donnelly, 2010: 110; Mackenzie & Rogers, 2013). Yet experience suggests that where mental capacity assessments are conducted by professionals, who may have little personal knowledge of the individual, it is harder to support people to make decisions (House of Lords Select Committee on the MCA, 2014, para. 70). By contrast, the support paradigm literature connected with the CRPD places a greater emphasis on personal and biographical – rather than clinical – knowledge, and the role of families and friends in supporting decision making (Bach & Kerzner, 2010). Involving family and friends may confer practical advantages over the medicalised approach to support taken in the MCA literature - people's decisions and social worlds extend far beyond the clinical. Herring (2013a, p. 157) argues that mental capacity assessments should routinely examine how people make decisions with the support of family and friends.

This brings us to one of the key instabilities in the MCA's treatment of supported decisions. Whilst on the one hand it endorses the idea that decisions can be made with support, too much 'social scaffolding' raises doubts about where the 'true' responsibility for the decision should lie. This dilemma is starkly illustrated by the case of *V v R*.³⁰ V sought compensation from a driver who had hit her in a road traffic accident, leading to multiple physical injuries and a head injury. In considering her mental capacity to conduct that litigation,³¹ the court heard that she relied heavily upon her mother for advice, and her mother felt she was incapable of making important decisions for herself. However, the court concluded that she had the mental capacity to litigate on the "clear understanding" that she would 'continue to receive the help, support and advice of her parents.'³² Yet in a later hearing, a different judge concluded that V lacked the mental capacity to make financial decisions *because* she relied so heavily on her mother's advice, saying "the guiding person in making the decision was her

²⁹ *Wandsworth Clinical Commissioning Group v IA* [2014] EWHC 990 (COP); *Re JB* [2014] EWHC 342 (COP)

³⁰ Note: This case is a personal injury claim and not a Court of Protection case. It is possible that a Court of Protection judge might take a different approach.

³¹ *V v R* [2011] EWHC 822 (QB)

³² §29

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mother."³³ No principled grounds for reaching different conclusions on very similar facts were provided.

V's case is another example of a fundamental ambivalence as to whether mental capacity has external constitutive elements; in this context the question is how far a person can be regarded as competent if they are reliant on their relationships with others to make decisions. Mental capacity approaches tend to draw a sharp distinction over where responsibilities lie; insofar as a person has mental capacity, they assume responsibility for the consequences of their decisions, even if harmful. Difficulties potentially arise if third parties have a powerful influence over a person's decision making, yet are neither responsible nor accountable for its outcome. Courts may be nervous of recognising 'supported' decisions where, as under the MCA, there is no obvious way of monitoring the conduct of supporters and holding them accountable. As we will see, the support paradigm literature connected with the CRPD advocates formal frameworks for support, which could address some of these concerns and offers more effective legal tools for recognition of shared or complementary responsibilities. This in turn might lead to greater willingness to recognise supported decisions which are highly influenced by third parties. Yet even within the support paradigm, difficult questions can still arise about where 'true' or ultimate responsibility for decisions lies.

Support and coercion

A key distinction between the MCA's approach to 'support' and the support paradigm connected with the CRPD is the extent to which support is consensual. In a number of cases under the MCA the 'support principle' has grounded interventions that conflicted with a person's expressed wishes. *The Mental Health Trust v DD* is an extreme example of this.³⁴ Following growing concerns by medical professionals and social workers about DD's inability to care for her children, five of whom had been removed from her care, and her refusal to engage with ante-natal care in the context of serious complications in previous pregnancies, they sought an assessment of her mental capacity to make decisions about contraception. Because DD refused to engage with professionals, the court authorised forced entry to her home and her removal to a health centre to be given 'education' about contraception and a capacity assessment.³⁵ Later judgments reported that this intervention had put

³³ *Verlander v Rahman* [2012] EWHC 1026 (QB)

³⁴ *The Mental Health Trust & Ors v DD & Anor* [2014] EWCOP 13

³⁵ The MCA Code of Practice states that 'Nobody can be forced to undergo an assessment of capacity' (Lord Chancellor's Office, 2007: [4.59]), however the Code is not legally binding. Although there must be good reasons for departing from a statutory Code's guidance: *R (Munjaz) v. Ashworth Hospital Authority* [2005] UKHL 58. See

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back efforts to foster co-operation³⁶ and resulted such high levels of anger and frustration that the assessment could not be completed.³⁷

In *A Local Authority v TZ*³⁸, TZ was found to lack the mental capacity to assess the risks of prospective sexual partners. The court ordered that he be given a named support worker who would oversee a "programme of education and empowerment", accompanying him on outings and reminding TZ of "appropriate behaviour".³⁹ The plan offered space for TZ to enjoy privacy and the opportunity to make "mistakes" in order to learn through experience, but this privacy was closely bounded. If TZ wished to leave his care home and cohabit with somebody, there would be an assessment of his mental capacity to make that choice. If TZ wished to bring a sexual partner back to his care home, they would be "subject to safeguarding checks to protect other residents".⁴⁰ One wonders if many people could initiate sexual relationships under such conditions.

The cases of DD and TZ reveal the significant potential for hard paternalistic intervention within the MCA's approach to 'support'. Superficially, they are based upon a view that coercion and control can be used to foster and enhance autonomy; a view that is rejected by Clough (2014), who argues that perpetuating a lack of choice and control over a person's own life increases their overall vulnerability. They contrast sharply with the approach to support connected with the CRPD; the General Comment states that support must be based on the person's will and preferences and that the person must be able to refuse support (para. 24).

'Relational best interests'

The literature on the MCA has also explored relational dimensions of best interests decisions made on behalf of a person who is said to lack mental capacity. Best interests decision makers must "so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to

also *SBC v PBA and Others* [2011] EWHC 2580 (Fam). The Court of Protection can make interim orders under s48 MCA on the basis that there is 'reason to believe' that a person lacks mental capacity, where no satisfactory assessment of mental capacity has yet been undertaken.

³⁶ *The Mental Health Trust & Anor v DD & Anor (No 3)* [2014] EWCOP 44, §5

³⁷ *The Mental Health Trust & Ors v DD & Anor* [2015] EWCOP 4, §42

³⁸ *A Local Authority v TZ (No. 2)* [2014] EWHC 973 (COP); see also the earlier decision in *A Local Authority v TZ* [2013] EWHC 2322 (COP).

³⁹ §64

⁴⁰ §62-71

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

participate, as fully as possible in any act done for him and any decision affecting him".⁴¹ They must "consider, so far as is reasonably ascertainable", the person's past and present wishes, feelings, values and beliefs.⁴² They must also, where "practicable and appropriate", consult with anyone named by the person and others involved in caring for them or with an interest in their welfare.⁴³

Dunn's (2008) describes the importance of 'relational' personal knowledge in best interests decisions made by care workers. Other scholars have considered how the interests of others can become ensnared with those of the individual and will need to be considered (Herring, 2013b; Herring & Foster, 2012; Martin et al., 2012). Some 'relational' accounts of best interests have a pronounced coercive undertow, however. A striking example of this is a hypothetical scenario described by Herring (2013b, p. 19-20; 2013a, p. 174-5) where he suggests that a person with incontinence problems could be subjected to surgery to correct this despite his refusal if his partner found dealing with his incontinence "unpleasant", in order to preserve this important relationship. Yet scenarios like this are precisely why disability rights campaigners emphasise the importance of non-familial sources of assistance being available (Campbell, 2008). An equalities perspective would pose the question: is this principle that important relationships are to be preserved through coercion to be extended to non-disabled people as well? It might be thought that this scenario displays characteristics of oppression that are critiqued in many RA accounts.

'Best interests' approaches are rejected in the support paradigm connected with the CRPD for not giving sufficient respect to an individual's 'will and preferences' (Jütten, 2014; General Comment, para. 18bis). The Supreme Court recently clarified that best interests requires consideration of matters "from the patient's point of view", but whilst it contains subjective elements it is not a substituted judgment approach.⁴⁴ Some reported best interests decisions do strive to make the decision the person would have made for themselves⁴⁵, but others are explicitly at odds with what the

⁴¹ s4(4) MCA

⁴² s4(6) MCA

⁴³ s4(7) MCA

⁴⁴ *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, §45, §24

⁴⁵ For example: *Westminster City Council v Sykes* [2014] EWHC B9 (COP); *PS v LP* [2013] EWHC 1106 (COP); *United Lincolnshire Hospitals NHS Trust v N* [2014] EWCOP 16

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

person presently wants⁴⁶ or would have wanted.⁴⁷ The contrasting approach taken by the support paradigm of the CRPD is discussed further below.

LEGAL CAPACITY AND THE SUPPORT PARADIGM UNDER THE CRPD

The support paradigm aims to offer a new and more “cosmopolitan” approach to legal capacity, based on ideas of “shared personhood” and an acknowledgement of universal reliance on myriad supports to “to help us forge our own pathways” (Quinn & Arstein-Kerslake 2012. p. 38). It is characterized by attempts to maximize the extent to which a person’s legal agency reflects their will and preferences, regardless of their perceived or actual mental capacity.

As a *sui generis* approach to legal subjectivity, the metaphysical and normative underpinnings of the support paradigm are still evolving. In some places in the literature, it appears to rest on a causal claim similar to Nedelsky’s (1989) argument that autonomy is always, for everyone, dependent upon supportive relationships which enable autonomy to develop, and that it is necessary to be given opportunities to make decisions, including mistakes, in order to develop autonomy. Others, like Silvers and Francis (2009) appear to be making a stronger constitutive claim: that provided they stand in an appropriate relationship with an individual, supporters can satisfy what would ordinarily be ‘internal’ competence criteria such that the person themselves is regarded as autonomous. On this model, third parties serve a “prosthetic” function, to whom ‘competence’ can be outsourced and yet decisions still remain authentically the person’s own. Metaphysically, this raises contested ‘extended mind’ arguments in the philosophy of mind (discussed by Nelson, 2009), and the metaphysics as such will not be discussed here. However, I offer some practical and legal reasons why it may be problematic to treat third parties’ decision making processes as if they were the person’s own.

This section considers the support paradigm by exploring some of the specific practices which have been proposed as recognizing and fostering this more cosmopolitan approach to legal capacity, and the issues arising therein.

⁴⁶ For example: *The Mental Health Trust & Ors v DD & Anor* [2014] EWCOP 13; *GW v A Local Authority & Anor* [2014] EWCOP 20.

⁴⁷ *Re JC; D v JC* (2012) MHLO 35 (COP)

Supported decision making

By 'supported decision making', I mean systems of supports where one or more people assist another to make a decision and communicate it to others.⁴⁸ This could be through helping them to obtain and understand information relevant to the decision, talking through the pros and cons of different available options, or helping a person to communicate with others. There is, clearly, considerable overlap between 'supported decision making' under the CRPD and some of the dialogical approaches described above in connection with the MCA. However, there are some core differences between supported decision making under the MCA and the CRPD.

Support under the CRPD tends to be construed in a much more holistic way than under the MCA; it is not only available when a person's mental capacity to make a specific decision is called into question, but for all and any areas of decision making where a person wants support. Earlier I highlighted the lack of attention paid within the MCA literature to the identity of supporters, and I contrasted the potentially coercive approach to support under the MCA with the highly consensual model favoured by the General Comment. The CRPD has focused attention on models of supported decision making where individuals exercise high levels of control over who supports them and how they are supported.

One such model was developed in a pilot project by the Office of the Public Advocate (2011) in South Australia. People with intellectual disabilities, brain injuries or neurological disease chose a trusted individual to support them and make written 'support agreements' that specified those areas where they wanted support in decision making and *how* they wanted to be supported. These could be tailored to the individual's preferences; for example, they might specify "Remind me to look forward and think of the future" or "[Listen] to me first and try and understand" (Office of the Public Advocate, 2011, p. 35).

The Personal Ombudsmen (PO) scheme, developed in Skåne, Sweden, by users of mental health services, is also often cited in the literature. POs are professionals – typically lawyers or social workers with no allegiance to psychiatry or social services – that work entirely on their clients' commission. Jespersen (2013) reports that clients' first priorities are often "existential" matters, and may not be the same as those of services and relatives. PO's must be willing to discuss these matters and resist the urge to simply "fix" things; after many months clients may trust their PO sufficiently to request help from them.

⁴⁸ Although the CRPD Committee do not follow this distinction in the GC, referring to a wide range of supports as 'supported decision making', including those that I have referred to here as 'facilitated decision making'. See also Gooding (2015) for discussion of this issue.

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

An evaluation of the South Australian pilot study found that it prevented entry into guardianship and many people successfully applied for 'administration orders' to manage their property and affairs to be lifted (Wallace, 2012). Studies of the PO system found clear benefits to clients in terms of meaningful occupations, social contacts and reductions in symptoms of psychiatric illness (Engman et al., 2008, p. 23). An economic analysis found that the PO scheme delivered significant savings because of the reduced need for crisis interventions and other services (Nilsson, 2006). These findings suggest that being able to choose and shape relationships of support can play a vital role in building trust, which in turn increases the likelihood that they will effectively foster personal autonomy. This is a clear strength of support paradigm.

The General Comment requires states to provide legal frameworks that offer formal legal recognition to a support person chosen by the individual (para. 25(d)) and several jurisdictions already offer such frameworks.⁴⁹ Formalising support has several attractions. It should give supporters greater leverage when accessing information on the person's behalf or helping them to communicate their views. It may be easier to detect and respond to exploitation and abuse in formalised support relationships (Carter & Chesterman, 2009). Procedural safeguards can potentially be built into formalised supports; for example, 'Representation Agreements' in British Columbia, Canada, allow a person to appoint a 'monitor' to monitor the activities of their chosen representative. Legislating for supported decisions can also clarify where legal responsibility for supported decisions lie – a key concern under the MCA, as we saw in the case of V.⁵⁰

However, informality may also be attractive in certain situations. The success of the PO scheme in gaining trust is attributed, in part, to its strong guarantees of confidentiality – no third party is informed that a person is using a PO's services, and all paperwork is retained by the client not the PO. This would be hard to replicate in a system where supporters had to be registered with an external body and submit to their monitoring. Instruments that allow supporters to act as a person's legal

⁴⁹ In Canada: Representation Agreement Act 1996 (British Columbia, Canada); The Adult Guardianship and Trusteeship Act 2008 (Alberta, Canada); The Adult Guardianship and Co-decision-making Act 2000 (Saskatchewan, Canada); Decision Making, Support and Protection to Adults Act, 2003 (Yukon, Canada). Similar frameworks may soon follow in Ireland (Assisted Decision-Making (Capacity) Bill 2013 (Ireland)) and Australia follow (Australian Law Reform Commission, 2014; Victorian Law Reform Commission, 2012).

⁵⁰ For example, s6(1) of the Adult Guardianship and Trusteeship Act (2008) (Alberta, Canada) states that 'A decision made with the assistance of a supporter or communicated by or with the assistance of a supporter is the decision of the supported adult for all purposes'.

representative⁵¹ may also increase their potential to *misrepresent* a person's decisions in legal transactions; for this reason Article 12(4) calls for safeguards to ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person and protect against exploitation and abuse. Legislating for support relationships can, in other words, change their character – both for better and for worse – and has knock on consequences on whether and how they foster autonomy.

The support paradigm does raise difficult metaphysical questions about 'ownership' of a decision, as discussed in relation to the case of V. Responding to this kind of concern, Silvers and Francis (2009, p. 485) argue that supporters should be viewed as a prosthesis for thinking, whereby their "reasoning and communicating can execute part or all of a subject's own thinking processes". Accordingly, they argue, we should attribute the functioning of the prosthesis to the agent using them: "The racer, not the metal foot, is taken to be running the race" (p. 486). Yet as Arstein-Kerslake (2014) observes, supporters – unlike prostheses – have minds of their own. It seems doubtful that supported decisions can somehow be cleansed of the personality and values of the support person as Silvers and Francis' model seems to suggest. The framing of choices *always* potentially alters the resultant decision; influence is inescapable for everyone (Quigley, 2013; Sunstein & Thaler, 2003). Yet logically, framing effects cannot *always* impair autonomous agency, or we should never be autonomous. The critical question is: *when* does 'influence' threaten authentic agency? In legal terms, the CRPD contains a distinction that is also found in English law, between influence and 'undue influence'. Yet defining the point at which influence becomes 'undue' is no easy matter, and is discussed below.

Self-binding directives and co-decision making

Although the support paradigm is generally highly consensual, the literature endorses instruments that give advance consent to measures that may conflict with a person's expressed will and preferences in the future (Flynn & Arstein-Kerslake, 2014; Minkowitz, 2013b). The best known of these 'self-binding directives' are Ulysses agreements⁵², where a person can specify what treatment or non-treatment they would like at a point in the future when they might change their mind. Ulysses agreements are based upon two connected ideas: firstly, that autonomy is diachronic, and we can

⁵¹ Such as Representation Agreements, see n49

⁵² So named after legendary Greek hero Ulysses (Odysseus), who wanted to hear the song of the sirens although it would render him incapable of rational thought and draw him to self-destruction. He asked his men to tie him to the mast of his ship as they sailed past the sirens, to plug their ears with wax and not to untie him whatever he might say (Bielby, 2014; Dresser, 1982; Radoilska, 2012).

enhance autonomous agency by binding our future selves; secondly, that interpersonal dynamics are a key element of self-determination, and we can deploy others to promote our own diachronic autonomy through “empowering kinds of reliance on others” (Radoilska, 2011, p. 266). Ulysses agreements do not necessarily require a person to be ‘incompetent’ in order to come into effect (Bielby, 2014). They can present “ethical hazards” because they require a person’s presently expressed wishes to be overruled; for example Walton (2003) gives the example of birth plans that prohibit the administration of pain relief even if a woman in labour later requests it. Dresser (1982) questions whether Ulysses agreements are as non-paternalistic as they aspire to be, highlighting the absence of any non-arbitrary basis for choosing which set of preferences – past or present – others are to treat as binding. Careful consideration needs to be given to when self-binding directives come into effect and how they can be revoked if the CRPD moves away from a mental capacity based model; what disability neutral criteria could be used to prefer a person’s decision at one time over another?

Co-decision making agreements rest on a similar logic to Ulysses agreements. They are provided for in several Canadian jurisdictions (James & Watts, 2014), and may soon be adopted in Ireland⁵³ and Australia (Victorian Law Reform Commission, 2012). A person nominates a co-decision maker through a formal agreement, usually requiring court authorization. Once in force, only acts that are agreed by both the person and their co-decision maker have legal force. Sometimes co-decision makers must acquiesce to a person’s decisions if a reasonable person could have made it.⁵⁴

Because of the potential for co-decision makers to veto a person’s choices, they are said to lean ‘more closely to a substituted decision-making model’ (James & Watts, 2014, p. 58). Yet they are potentially useful for people who trust a third party to make decisions on their behalf but who wish to remain involved and informed and retain the ability to veto decisions that they do not agree with. They might potentially be useful for people who sometimes make impulsive decisions that they later regret, who would like a trusted third party to ‘sign off’ on important legal decisions. Like Ulysses agreements, questions may arise as to how easily a person can dismantle a co-decision making agreement. At present most statutes require a person to have the mental capacity to do so. A move away from a mental capacity standard would need to carefully consider how to strike an appropriate balance between a person’s ability to extricate themselves from an agreement that was not working for them

⁵³ Assisted Decision-Making (Capacity) Bill 2013 (Ireland)

⁵⁴ s17(2) The Adult Guardianship and Co-decision-making Act 2000 (Saskatchewan, Canada); see also s19 Assisted Decision-Making (Capacity) Bill 2013 (Ireland)

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

without making them so easy to dismantle it undermined the entire purpose of an instrument designed to iron out fluctuations in expression of agency.

Facilitated decision making

Facilitated decision making is one of the most conceptually challenging elements of the support paradigm. It was first developed by Bach and Kerzner (2010) for situations where there was nobody in a person's life who could reliably understand their communication in order to support them to make decisions. Bach and Kerzner's model proposes that a third party (a "facilitator") takes "needed decisions" on the person's behalf, but bases their decisions on their knowledge of a person's "narrative". Facilitated decisions may comprise elements that are similar to 'substituted judgement' approaches, taking into account a person's past known values, beliefs and preferences (Flynn & Arstein-Kerslake, 2014), but they are also sensitive to *present* expressions of agency, even if they might not be regarded as 'rational' or 'competent'. For example, the kinds of 'practical' and 'creative' agency Boyle (2014) describes people with dementia exercising. Quinn (2011) writes of obligations "to spark the expression of their will and preference through time".

Understanding why facilitated decisions are not 'substitute decisions', and thereby prohibited within the support paradigm, requires a careful reading of the General Comment. Facilitated decisions would not fall within its threefold definition of substitute decisions⁵⁵ *provided* they did not void any discernible efforts to exercise legal agency, did not involve appointing a facilitated decision maker against the person's will, and any decisions were made on the basis of the facilitator's "best interpretation" of the person's will and preferences, rather than their objective 'best interests' (General Comment, para. 18bis). Such approaches are described as more 'intensive' forms of support (paras. 15-16 and 25(b)).

It is important to consider the positioning of facilitated decisions within the wider political context of the CRPD. During the negotiations of the Convention, the International Disability Caucus resisted any language that might legitimize guardianship, such as permitting 'substitute decisions' in exceptional cases. They proposed instead that sometimes it might be necessary to provide "100% support".⁵⁶ Consequently in some places in the literature on the CRPD, facilitated decisions seem to be treated as a person actively exercising legal agency with support, rather than a third party taking decisions on their behalf (e.g. Flynn and Arstein-Kerslake, 2014, p. 96; World Association for Psychosocial Rehabilitation, 2014). These evoke the strong metaphysical claim made by Silvers and Francis that

⁵⁵ At para. 23

⁵⁶ See the *travaux préparatoires* for 18 January 2006 (UN Enable, 2010).

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

supporters could potentially exercise “*all* of a subject’s own thinking processes”⁵⁷ and yet the person and not the supporter would be regarded as the agent making the decision.

Others – myself included – prefer to treat “100% support” as a ‘legal fiction’ rather than a metaphysical reality, and prefer a clearer recognition that the facilitator – not the person themselves – is taking the decision (Booth Glen, 2012; Canadian Association for Community Living, 2014; Gooding, 2015; Mental Disability Advocacy Center, 2014; People with Disability Australia et al., 2014; Quinn, 2010). Facilitated decisions take place because we are *uncertain* as to what a person wants; they call for *interpretation* (General Comment, para. 18bis). It is important to recognize that facilitators have considerable power to alter a person’s ‘narrative’ through their interpretation. They will get it wrong sometimes; if the person later on becomes able to communicate their wishes, it seems nonsensical to tell them that the decision was their own, especially if they do not recognize it as one which they would have made. Recognizing that facilitated decisions are decisions that have been made *on behalf of* the person, not by them, keeps in view these important epistemic considerations and the power and responsibility of facilitators. It is perhaps in recognition of these factors that Bach and Kerzner’s model includes more stringent safeguards for facilitators than supporters, and prohibits them from making certain decisions where there is a high risk of abuse or exploitation.

Facilitated decision making stretches the concept of RA to its limits. It relies upon others being able to “tell a coherent story about who we are” (Bach & Kerzner, 2010, p. 65). The epistemic issues in facilitated decision making are no less considerable than those of dialogical mental capacity assessment. The support paradigm does not purport to offer tools to magically overcome this. Rather, facilitated decisions entail (at least) three separate moral obligations. First, to strive for the best interpretation we can – albeit this may be very difficult – of what a person wants or would have wanted. Second, to maximize their potential to express what they want more clearly. Thirdly, having come to our best interpretation of what they want, to convert that into legal effect on their behalf. This differs from best interests. Some best interests decision makers *do* go to great lengths to make the decision the person themselves would have made⁵⁸. But as Hayden J put it recently in a case where he had gone to great lengths to understand the possible wishes of a man in a minimally conscious state, “Wishes’ and ‘best interests’ should never be conflated, they are entirely separate

⁵⁷ Emphasis mine

⁵⁸ *Westminster City Council v Sykes* [2014] EWHC B9 (COP)

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

matters'⁵⁹. Best interests decision makers are not bound by their best interpretation of what a person wants or would have wanted, facilitators are.

Hard cases: risk and harm

A common criticism of the support paradigm is that it offers few tools to mitigate harmful decisions (Kohn & Blumenthal, 2013; Ward, 2014). The literature embraces disabled peoples' right to a "dignity of risk" (Gooding, 2012). It focuses on non-coercive interventions that could mitigate risks, counters stereotypes of 'dangerousness' and interrogates "the impulse towards protection" (Minkowitz, 2013a, p. 17). It also highlights the risks of abuse and exploitation that guardianship and mental health laws themselves pose (Dhanda, 2006-7). However, there is growing recognition that there will be 'troubling' situations where a person's acts or choices place them at serious risk, risks that they do not understand, where the support paradigm offers no clear or obvious solutions. Gooding (2015), for example, quotes from Farr's (1982) first person account of psychosis, where she believed that only by jumping from the seventh floor of a building and landing on her head would she receive the ultimate Enlightenment.

The support paradigm is imbued with a desire to protect "psychiatrized persons and others from attributions of incapacity" based on "value-laden assessments of the risks and benefits at stake" (Wildeman, 2013, p. 60). It is very difficult to think of legal principles and safeguards to cope with these dilemmas that would not provide a toehold for full blown guardianship and civil commitment regimes to creep back in. Moreover, in discussing hard cases there is a danger that they will be rhetorically deployed as "extreme case formulations" (Pomerantz, 1986) to legitimize the very practices the CRPD sought to eradicate. And yet... these hard cases *do* exist, and when we are confronted with them we would hope that the support paradigm could supply some clear principles and safeguards for dealing with them. To do otherwise risks situations of domination where the principles governing such interventions are unclear and arbitrary, and in common law jurisdictions creates space for the courts to develop paternalistic principles to fill any lacunae.⁶⁰

The literature on the support paradigm offers some tentative proposals for dealing with hard cases of risk, but these are difficult to reconcile with the General Comment – and, indeed, with each other.

⁵⁹ *Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor* [2014] EWOP 4 §56. See also paragraph 5.38 of the MCA Code of Practice, which states that 'their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests.'

⁶⁰ As it did, for example, in *Re F. (Mental Patient: Sterilisation)* [1991] UKHL 1, the case that formed the basis of the MCA itself.

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

Bach and Kerzner's (2010, p. 140, p. 144) Serious Adverse Effects framework permits facilitators to intervene when a person "can no longer express his will and/or intentions in ways that would direct reasonable consequential action". This appears to be a modified outcome approach: we identify the outcome we think a person *really* wants, based on our knowledge of them, and use that to guide interventions which they may resist because their behaviour is not 'reasonable' in light of that preferred outcome.

Recently the Canadian Association for Community Living (2014), whose Executive Vice-President is Michael Bach, seemed to endorse an "understand and appreciate" test to determine whether people "know what they are doing, they are choosing dignity of sometimes substantial risk". The Mental Disability Advocacy Center (2013)⁶¹ has also suggested a modified mental capacity approach, recommending removing the more overtly subjective elements of the functional test, such as 'use or weigh' requirements, and requiring understanding of minimal information. It might also be possible to restrict capacity assessments to situations of serious risk to avoid their permeating all of a person's decisions.

Flynn and Arstein-Kerslake (2014) suggest that in cases of serious self-harm those around a person could act 'against the explicit instructions of the person being supported' in emergency situations "where supporting the person's wishes would constitute civil or criminal negligence"⁶² (p. 99). By restricting such interventions to 'emergency' situations, presumably this would not encompass the kinds of distal risks presented in DD and TZ's case. They reconcile this position to the CRPD's emphasis on respecting a person's will and preferences by arguing that sometimes a person's present acts or verbal expressions diverge from their 'true' will and preferences; saying that third parties should "support the individual by taking whatever actions are necessary to augment her decision-making ability to a point at which she can clearly express her will and preferences" (p. 98).

Each of these approaches rests on the plausible intuition that that sometimes we experience temporary disturbances in authentic and autonomous agency. Yet they *also* confer epistemic privilege, and thereby power, upon others, in assuming that they will be able to accurately detect these disturbances, and intervene accordingly. Any law that legitimates interventions on these

⁶¹ For an example of a 'minimal' requirement for understanding for consent to sex, see s5A(4) Criminal Law (Sexual Offences) (Amendment) Bill 2014 (Ireland)

⁶² Presumably this would not be the civil and criminal laws of negligence as they are currently defined in England and Wales, since these *are* predicated on mental incapacity, as are similar positive obligations under human rights law, see: *Tomlinson v. Congleton Borough Council & Ors* [2003] UKHL 47; [2004] 1 AC 46; *Rabone & Anor v Pennine Care NHS Foundation* [2012] UKSC 2 and *Arskaya v Ukraine* (App no 45076/05) [2013] ECHR 1235.

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

grounds *necessarily* positions others as sometimes knowing ourselves better than we do, with all the epistemic uncertainty and power relations this entails. Without wishing to dismiss the claim that sometimes others *are* able to identify situations where we are 'not ourselves', it is not immediately obvious that a claim to know a person's *true* will and preferences better than they do is a preferable basis for coercive intervention, or is any less prone to subjective and arbitrary interpretation, than mental incapacity and best interests, or even risk.

The CRPD injects another element, however, into hard cases. It calls for recognition that vulnerability and risk is a universal phenomenon with a complex aetiology, and is not limited to people with disabilities or mental disorders (Clough, 2014; Scully, 2014). On this view, the CRPD calls for a *disability neutral* response to risk and vulnerability. There are examples in English law of generic obligations to protect vulnerable persons from self-inflicted harm, such as the duty to prevent prisoner suicides, even if the prisoner has no mental disorder.⁶³ Increasingly the courts' 'inherent jurisdiction' is used to intervene in situations where people have 'mental capacity' but are regarded as vulnerable as a result of their situation (Szerletics, 2011). This offers a potential model for disability neutral interventions (Clough, 2014).

However, the possibility of non-consensual interventions for those without mental disorders has caused consternation among some liberal theorists (Christman, 2004; Holroyd, 2009) and indeed the general public (Department of Health, 2013). Requirements for disability neutrality also potentially conflict with older international human rights instruments that require an explicit finding of 'mental disorder' for coercive interventions, and the idea of laws permitting preventive detention on a *generic* basis has raised concerns of political abuse (Bartlett, 2012a; Fennell and Khaliq, 2011). The CRPD forces us to confront the question: why are measures to mitigate risk and vulnerability that are considered acceptable when imposed on people with mental disabilities considered unacceptable if imposed on the population as a whole (Bartlett, 2012b)? Perhaps if interventions were framed in terms that could potentially affect anybody, we would proceed with greater caution.

Hard cases: undue influence

Proponents of the support paradigm and critics alike have expressed concern about the potential for undue influence, exploitation and abuse by supporters (Carter & Chesterman, 2009; Kohn & Blumenthal, 2013; Minkowitz, 2013b; Ward, 2011). These echo the intuition in the RA literature that

⁶³ *Commissioners of Police for the Metropolis v Reeves* [1999] UKHL 35; [2000] 1 AC 360. Although, this does sit in tension with cases finding that there are no grounds to forcibly feed a prisoner who stages a hunger strike, because he is of 'sound mind' *Secretary of State for the Home Department v Robb* [1995] Fam. 127.

external conditions of duress, manipulation and coercion can impair authentic expressions of autonomy (Ashley, 2013; Stoljar, 2013). The case of G, described above, is a good example of the kinds of situations we are concerned with here. These are issues that potentially affect *all* people (Gooding, 2015), but as the General Comment acknowledges “may be exacerbated for those who rely on the supports of others to make decisions” (para. 18ter). Article 12(4) CRPD requires safeguards to ensure that all measures relating to the exercise of legal capacity must ‘prevent abuse’ and ensure that they “respect the rights, will and preferences of the person, are free of conflict of interest and undue influence”.

Undue influence is notoriously difficult to define⁶⁴, raising difficult questions about *when* we should regard influence as undue. The General Comment characterises it as “where the quality of the interaction between the support person and the person being supported includes signs of fear, aggression, threat, deception or manipulation” (para. 18ter).⁶⁵ The General Comment’s focus on the *interaction* rather than the outcome of the decision resembles procedural accounts of RA which aspire to value-neutrality (Stoljar, 2013). They also have parallels with ‘discursive control’ accounts of freedom, which Craigie (2015) argues could offer practical guidelines for the support paradigm. Importantly, on this interaction/procedural view of undue influence, support would not be regarded as ‘undue’ simply because a person relied extensively upon others for support, nor because they had arrived at a decision that others regarded as harmful, or because others disapproved of their choice of support person.

The General Comment’s definition of undue influence appears to capture cases like *London Borough of Redbridge v G*, where G’s decisions could easily be viewed as a product of fear, aggression and manipulation by C and F. Conversely it would not capture situations like *V v R*, where V’s mother did potentially exercise great influence over her, but this interaction was not characterized by aggression, manipulation or deceit. Other MCA cases on ‘undue influence’ might come out differently, however, on an interaction approach. For example, in *A Primary Care Trust v P* it was held that P’s views were so ‘unhealthily enmeshed’ with those of his mother that he lacked mental capacity⁶⁶ - but it is unclear

⁶⁴ *Royal Bank of Scotland v. Etridge* (AP) [2001] UKHL 44, §86

⁶⁵ This definition is more expansive than the equitable doctrine of ‘undue influence’ in English contract law, seeming to embrace related doctrines of ‘duress’, ‘unconscionable bargain’ and ‘misrepresentation’. For descriptions of these doctrines in contract law, see Peel (2011).

⁶⁶ [2009] EW Misc 10 (EWCOP)

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

that this reflected concerns about fear, aggression or manipulation so much as her having *too much* influence whilst being regarded as a *bad* influence.

In English law, contracts entered into under undue influence or duress can be set aside, but the affected individual must take steps to do this. Some jurisdictions with formalized support agreements require third parties to disregard 'supported decisions' if they have reasonable grounds to believe that the supporter exercised undue influence, or there was fraud or misrepresentation on their part.⁶⁷ Safeguards could be developed whereby – as is the case in English law – where there is a presumption of undue influence by a supporter, it must be rebutted, for example by showing that the person had been given access to independent advice (Peel, 2011, para. 10-026). Similar mechanisms might also be useful for situations where there is concern that supporters with 'conflicts of interest' may have taken advantage of their position. It will be extremely hard to avoid conflicts of interest in supporters, since many will either have personal connections or may potentially provide them with services for remuneration, so techniques for managing them will be essential.

By definition, people in situations of undue influence will have difficulty expressing their 'true' will and preferences and may, like G, be too scared to ask for assistance. How should a paradigm that is premised on maximum respect for will and preferences respond in situations of suspected undue influence, exploitation and abuse, where the person themselves indicates a preference to remain in that situation? In these situations, it is difficult to navigate the support paradigm's embrace of a dignity of risk in allowing a person to choose to enter into potentially harmful relationships, and its emphasis on recognizing 'true' expressions of will. The General Comment itself specifies that safeguards to protect against undue influence 'must also respect the rights, will and preferences of the person, including the right to take risks and make mistakes' (para. 18ter). As yet, the literature on how to proceed in these situations is limited.

Arstein-Kerslake (2014) outlines a case study of 'Joe', who has high support needs and whose father heavily influences his decisions and sometimes acts paternalistically towards him. Following a temporary spell in respite care it is decided that it is not in Joe's best interests to return to live with his father, but Joe still wishes to return there. Arstein-Kerslake contends that the state has a role in ensuring that Joe has the necessary support to understand that other options than living with his father exist, but that "if he ultimately chose to remain in his father's home, under his father's control, that decision must be respected" (p. 11). Arstein-Kerslake's case study illuminates how the 'dignity of risk' extends to choices to engage in controlling or otherwise risky relationships.

⁶⁷ s6 The Adult Guardianship and Trusteeship Act 2008 (Alberta, Canada)

The case study evokes both *A Primary Care Trust v P*, where P continued to express a preference to live with his mother even after experiencing other living options, and *LBX v K* where L expressed a preference not to return to his father's care after experiencing life elsewhere. The analysis rests on allowing a person to make an informed choice between different options; yet experience suggests that sometimes it can be extremely difficult to support a person to make such an informed choice if access to them is impeded by others. In G's case, for example, those concerned for her welfare found it almost impossible to visit her without C being present, and any information they managed to convey about the alternative support options available to her was contradicted by C. If we are to take seriously the idea that a person in this position must be given support to make a truly informed choice, in some exceptional cases stronger legal tools for intervention may be required. Use of the 'inherent jurisdiction' to restrain the actions of others who might impede a person's autonomous choices – for example, through non-molestation orders⁶⁸ or orders prohibiting a person's family from making arrangements for her marriage without her consent⁶⁹ – might provide a potential model. As with the interventions described earlier, however, there is a danger that they could be used in ways that go against the ethos of the support paradigm, and would need to be carefully considered.

CONCLUSION

Examining the MCA through the lens of RA reveals that the MCA was built upon two conflicting premises: causation requirements are premised on the idea that autonomy is a function of a person's individual psychological makeup, whilst the support principle and some parts of the case law on undue influence and mental capacity are based on the idea that sometimes autonomy can be affected by our external circumstances. This unstable underpinning has resulted in somewhat contradictory rulings regarding mental capacity, support and relationships with others.

The RA literature that has focused on the MCA has often taken a very narrow approach to 'support', whilst the support paradigm of the CRPD offers refreshing ways of thinking about how relationships can foster diachronic and relational autonomy in the exercise of legal capacity. Models such as co-decision making, supported and facilitated decision making are rich with potential for more sophisticated RA theories.

Yet both approaches to legal capacity are haunted by intractable epistemic difficulties. Whether one is assessing mental capacity, making a facilitated decision, trying to decide whether self-harming

⁶⁸ *DL v A Local Authority & Ors* [2012] EWCA Civ 253

⁶⁹ §131, §133

Post-print of article: Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

behaviour is a manifestation of a person's 'true' will and preferences or determining what to do in cases of undue influence, there is significant scope for interpretation, and therefore uncertainty and subjective decisions. This, in turn, confers considerable power and epistemic authority upon those responsible for such interpretations. Both models of legal capacity oblige us to come to a view *at some point* about whether a person is exercising autonomous agency, albeit that their constructions of autonomy may differ. It is difficult to see how these issues can be avoided.

The CRPD has revived old debates about the legitimacy of non-consensual interventions, and poses new questions about the nature of disability and how people with impairments might best be enabled to exercise their rights on an equal basis with others. The CRPD does not of itself answer every question it poses – what human rights instrument does? Instead, as Wildeman (2013) comments, it has an expressive function, and creates an opening for discussions that challenge deeply entrenched practices and ways of thinking about legal subjectivity. The CRPD also offers important new tools for approaching these discussions through its powerful focus on equality, autonomy and the *external* determinants of disablement, vulnerability and risk. Perhaps most importantly of all, the CRPD insists that deliberation of policies and laws relating to people with disabilities actively involve them,⁷⁰ rather than being delegated to the very 'experts' they so often empower.

There is only a very sparse literature on the experiences of people who are subject to guardianship and mental capacity laws;⁷¹ this urgently needs remedying. If it is anything like the literature on subjective experiences of mental health laws, we should anticipate a diversity of views, but with a significant proportion feeling that coercive interventions were unjustified or unwelcome (for example, see: Katsakou and Priebe, 2006; Katsakou et al., 2010; Katsakou et al., 2012; Priebe et al., 2010; Russo and Rose, 2013). These studies also tell us that the quality of *relationships* play a key role in people's experiences of such interventions (Gilburt et al., 2008). RA approaches do not lead us to a clearly defined set of practices, but they do suggest that the law can no longer approach questions of legal capacity as a matter of individual rationality.

⁷⁰ Article 4(3) CRPD; Article 29 CRPD

⁷¹ For a recent example, see: European Union Agency for Fundamental Rights (FRA) (2013)

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